Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 09/17/01, 09/18/01, and 09/21/01.
   b. The request was received on 03/20/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs-1500
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. HCFAs-1500
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/19/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/21/02. The response from the insurance carrier was received in the Division on 07/08/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request. A timely, carrier initial response dated 06/04/02 is reflected in Exhibit II.

4. Notice of Additional Information submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 03/20/02
   "On all three dates, therapeutic exercise (97110) was paid inappropriately. This code is a per-unit code, and is to be billed in 15-minute increments. This code, regardless of the

number of units, counts as only one treatment modality. There were four units billed on each day, but only one was paid for."

2. Respondent: Response is untimely

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 09/17/01, 09/18/01, and 09/21/01.

2. Per the provider's TWCC-60, the amount billed is $420.00; the amount paid is $105.00; the amount in dispute is $315.00.

3. The carrier denied the billed services by code, "9 – F – Fee Guideline/Exceeds number of allowable procedures in the Medical Fee Guideline."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Codes	MAR$	REFERENCE	RATIONALE:
09/17/01 09/18/01 09/21/01	97110 97110 97110	$140.00 $140.00 $140.00	$35.00 $35.00 $35.00	F F F	$35.00 per 15 min	MFG MGR (I) (A) (9) (b); (I) (A) (10) (a); CPT descriptor	MFG MGR (I) (A) (9) (b) states, "Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting, is required)." (I) (A) (10) (a) states, "A physical session is defined as any combination of four modalities…procedures (97110-97150) and/or physical medicine activities and training…" CPT code 97110 is a one-to-one, timed code. The provider does not exceed the combination of four physical session modalities per day, but the provider fails to meet the one-to-one criteria for CPT code 97110. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." The Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation.

							The provider's **THERAPY** notes for each date of service read the same including the same misspelled word, "(Claimant) performed supervised exercises prescribe [sic] by me, to relax the muscle tissues of the affected area. **Thsi** [sic] muscle activity is to improve functional performance. The goals were to gain strengths, stretch, flexibility in the areas of the lumbar spinal region and the buttocks on the right (Claimant received 4 units of therapy on this visit)." The provider fails to identify the types of activities/therapies the claimant is performing on each date of service. The provider fails to document the duration of each activity/therapy, therefore, the notes do not support the time billed on each HCFA for CPT code 97110. There is no direct statement as to who is conducting the sessions. In the notes for each dos, the provider states, "(Claimant) performed supervised exercises prescribe [sic] by me." , but no specific titled worker who conducted the sessions is reported. The provider failed to indicate that the exercises were performed in a one-on-one setting. The word "supervised" is used in the notes describing the claimant's therapy. There is no documentation that indicates that the activities require one-on-one therapy sessions. The provider fails to document or substantiate any medical condition or symptom which the claimant presents that mandates one-on-one supervision for an entire session. The notes do not reflect the need for one-on one supervision tapering off over time as the claimant becomes more familiar with the exercises. The provider fails to meet the criteria of one-on-one documentation, therefore, no reimbursement is recommended.
Totals		$420.00	$105.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 14th day of October 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm